DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 11096 (Rev. 03/06)

STATE OF WISCONSIN

WISCONSIN MEDICAID
PRIOR AUTHORIZATION / HOME CARE ATTACHMENT (PA/HCA)

Instructions: Print or type clearly. Refer to the Prior Authorization/Home Care Attachment (PA/HCA) Completion Instructions, HCF 11096A, for information on completing this form.

SECTION I — RECIPIENT INFORMATION

1. Prior Authorization Number	2a. Name and Telephone Number — Recipient	2b. Recipient Medicaid Identification Number

3. Start of Care Date	4. Certification Period
	From To

SECTION II — PERTINENT DIAGNOSES AND PROBLEMS TO BE TREATED

5. Principal Diagnosis (ICD-9-CM Code, Description, Date of Diagnosis)	6. Surgical Procedure and Other Pertinent Diagnoses (ICD-9-CM Code, Description, Date of Procedure or Diagnoses)

SECTION III — BRIEF MEDICAL AND SOCIAL INFORMATION

7. Durable Medical Equipment

8a. Functional Limitations

1 ❑ Amputation	5 ❑ Paralysis	9 ❑ Legally Blind
2 ❑ Bowel / Bladder (Incontinence)	6 ❑ Endurance	10 ❑ Dyspnea with Minimal Exertion
3 ❑ Contracture	7 ❑ Ambulation	11 ❑ Other (Specify in Element 8b)
4 ❑ Hearing	8 ❑ Speech	

8b. If "Other" checked in Element 8a, specify other functional limitations.

9a. Activities Permitted

1 ❑ Complete Bedrest	6 ❑ Partial Weight Bearing	10 ❑ Wheelchair
2 ❑ Bedrest BRP	7 ❑ Independent at Home	11 ❑ Walker
3 ❑ Up As Tolerated	8 ❑ Crutches	12 ❑ No Restrictions
4 ❑ Transfer Bed / Chair	9 ❑ Cane	13 ❑ Other (Specify in Element 9b)
5 ❑ Exercises Prescribed		

9b. If "Other" checked in Element 9a, specify other activities permitted.

10. Medications (Dose / Frequency / Route)

11. Allergies

Continued

Prior Authorization Number

12. Nutritional Requirements

13. Mental Status
1 ❑ Oriented 3 ❑ Forgetful 5 ❑ Disoriented 7 ❑ Agitated
2 ❑ Comatose 4 ❑ Depressed 6 ❑ Lethargic 8 ❑ Other ___

14. Prognosis
1 ❑ Poor 2 ❑ Guarded 3 ❑ Fair 4 ❑ Good 5 ❑ Excellent

SECTION IV — ORDERS

15. Orders for Services and Treatments (Number / Frequency / Duration)

Continued

Prior Authorization Number

16. Goals / Rehabilitation Potential / Discharge Plans

SECTION V — SUPPLEMENTARY MEDICAL INFORMATION

17. Date Physician Last Saw Recipient	18. Dates of Last Inpatient Stay Within 12 Months (If Known)	19. Type of Facility for Last Inpatient Stay (If Applicable)
	Admission: Discharge:	

20. Current Information (Summary from Each Discipline / Treatments / Clinical Facts)

21. Home or Social Environment

22. Medical and / or Nonmedical Reasons Recipient Regularly Leaves Home (Include Frequency)

Continued

Prior Authorization Number

23. Back-up for Staffing and Medical Emergency Procedures (Required for All Providers Requesting Private Duty Nursing Services / Optional for Other Home Care Services)

SECTION VI — SIGNATURES

Nurse Certification

As the nurse completing this PA/HCA, I confirm the following: All information entered on this form is complete and accurate and I am familiar with all of the information entered on this form. When I am providing services, I am responsible for ensuring that this PA/HCA is carried out as specified.

24. **SIGNATURE** — Authorized Nurse Completing Form	25. Date Signed — Authorized Nurse Completing Form

26. Date of Verbal Orders for Initial Certification Period	27. Date Received Physician-Signed Form

Physician Certification

The recipient is under my care, and I have authorized the services on this PA/HCA.

28. Name and Address — Attending Physician (Street, City, State, Zip Code)

29. **SIGNATURE** — Attending Physician	30. Date Signed — Attending Physician

Case Sharing Nurse in Independent Practice Certification

As the nurse countersigning this PA/HCA, I confirm the following: All information entered on this form is complete and accurate and I am familiar with all of the information entered on this form. When I am providing services, I am responsible for ensuring that this PA/HCA is carried out as specified.

31. **COUNTERSIGNATURE** — Nurse in Independent Practice (Only if Sharing Case)	32. Date Countersigned — Nurse in Independent Practice

Anyone who misrepresents, falsifies, or conceals essential information required for payment of state and/or federal funds may be subject to fine, imprisonment, or civil penalty under applicable state and/or federal laws.

Reset form